August 21, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0858-01-SS
IRO Certificate No.: IRO 5055

Dear Mr.

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating physician. Your case was reviewed by a physician reviewer who is Board Certified in Neurology and Pain Management.

THE PHYSICIAN REVIEWER **DISAGREES** WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE. The REVIEWER HAS DETERMINED THAT L4-5 DECOMPRESSION FUSION INSTRUMENTATION IS MEDICALLY NECESSARY IN THIS CASE.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you five (5) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on August 21, 2002.

Sincerely,

**MEDICAL CASE REVIEW**

This is for ___. I have reviewed the medical information forwarded to me concerning TWCC Case File #M2-02-0858-01-SS, in the area of Orthopedic Spine Surgery. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of posterior lumbar fusion.
2. Correspondence.
3. History and physical and office notes.
4. Operative report.
5. Radiology reports.

B. BRIEF CLINICAL HISTORY:

The patient is an approximately 30-year-old gentleman who, in November of 2000, underwent L4-5 decompression for a herniated disk and stenosis at that level. Postoperatively, according to the notes, the patient recovered, but then had a recurrence of his back pain and now pain into the right lower extremity.

C. DISPUTED SERVICES:

___, 4/30/02, has given authorization for revision decompression at L4-5. However, on 3/27/02, denied authorization for L4-5 decompression and fusion.

D. DECISION:

1. I AGREE WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THE MATTER OF THE REVISION DECOMPRESSION AT L4-5.

2. I DISAGREE WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THE MATTER OF THEIR DENIAL FOR L4-5 FUSION.

E. RATIONALE OR BASIS FOR DECISION:

Given the most recent MRI and CT myelogram reports, on 10/09/01, there is an MRI report of lumbar spine showing the patient has a recurrent right L4-5 disk herniation. Review of the prior MRI of the lumbar spine dated 3/14/01, at L4-5, there are degenerative changes of the disk. Finally, review of the CT myelogram report reveals evidence of a wide laminotomy at L4-5.

Given the patient's current symptomatology on the clinic notes, of back pain and right leg pain, the revision decompression would be to address the right leg pain. Given the fact that the patient already has a wide laminotomy at that segment, further decompression would de-stabilize this segment.

Furthermore, given that the patient already has degenerative changes as evidenced on MRI reports, the patient's back pain most likely is due to either the degenerative changes at this segment or instability at this level. Therefore, fusion at L4-5 is also necessary in addition to the decompression.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this

evaluation. My opinion is based on the clinical assessment from the documentation provided.

_____

Date: 20 August 2002